4-000 The Basic Benefits Package

4-001 Introduction: 482 NAC 4-000 sets forth the responsibilities of the Primary Care Physician (PCP) and medical/surgical plan in delivering the Basic Benefits Package to the NHC client. While the PCP is responsible for providing the client a medical home and ensuring appropriate health care services, the medical/surgical plan, as the contracting entity with the Department, assumes primary administrative and operational responsibility for the development and implementation of the NHC programmatic requirements. In developing its program for the delivery of the Basic Benefits Package, and all related aspects of the NHC, the medical/surgical plan ~~shall~~ must incorporate the information contained in this Title, as well as 471 NAC, which defines in detail the minimum service provisions required for the NHC under the Nebraska Medical Assistance Program (NMAP).

The NHC delivers the Basic Benefits Package to Medicaid clients through one or more Health Maintenance Organizations (HMOs) and a Primary Care Case Management (PCCM) Network.

4-002 Primary Care Physician (PCP): The following provisions describe the PCP's responsibilities in the NHC.

4-002.01 Functionality of the PCP: The client chooses or is assigned to a Primary Care Physician (PCP). The PCP is the physician who provides a medical home for the client and is responsible for referrals for all medically necessary services. Authorization for physician to physician referral is not required. PCPs may participate in one or all of the HMOs, and/or in the PCCM Network. The PCP must be a Medicaid-enrolled provider (see 482-000-21, Medicaid Provider Enrollment Guide, and 471 NAC 2-000). A specialty care physician may function in an extended capacity with the PCP in certain circumstances with medical/surgical plan approval (see 482 NAC 4-002.02A).

4-002.02 Types of Providers: To participate in the NHC, a PCP must be a primary care physician whose primary expertise is in family practice; general practice; pediatrics; internal medicine; or obstetrics/gynecology, as identified as the primary specialty in the Department's Provider File System. These five specialties will be available for the client to choose as his/her PCP in either the HMO or PCCM Network (see 482-000-22, Provider Network File Guide).

For teaching clinics, the client ~~shall~~ must choose the facility's attending physician in the teaching clinic as the PCP, even though the clinic's resident actually provides care to the client. This attending physician ~~shall~~ must supervise and approve on all medical care provided to the client.

4-002.03 Limit on Number of Enrollees: A PCP is allowed to care for no more than 1500 Medicaid clients. When a PCP employs one or more physician extenders (i.e., nurse practitioners, physician assistants, certified nurse midwives, second-year and third-year residents), the PCP may care for up to an additional 500 clients, for a total of 2000 Medicaid clients. This allowable limit is referred to as PCP "slots." PCP limitations will be maintained in the Department's Provider Network File.

4-002.04 PCP Qualifications and Responsibilities: To participate in the NHC, the PCP must:

1. Be a Medicaid-enrolled physician and agree to comply with all pertinent Medicaid regulations;
2. Sign a contract with the medical/surgical plan as a PCP which explains the PCP's responsibilities and compliance with the following NHC requirements:
   a. Treat NHC clients in the same manner as other patients;
   b. Provide the Basic Benefits Package per 471 NAC to all clients who choose or are assigned to the PCP's practice according to the Enrollment Report and comply with all requirements for referral management and prior-authorization;
   c. When medically necessary, coordinate appropriate referrals to services that typically extend beyond those services provided directly by the PCP, including but not limited to specialty services, emergency room services, hospital services, nursing services, mental health/substance abuse (MH/SA), ancillary services, public health services, and other community based agency services, and ensure such services are provided by Medicaid-enrolled providers. Authorization for physician to physician referral is not required;
   d. As appropriate, work cooperatively with specialists, consultative services and other facilitated care situations for special needs clients such as accommodations for the deaf and hearing impaired, experience-sensitive conditions such as HIV/AIDS, self-referrals for women's health services, family planning services, etc.;
   e. Provide continuous access to PCP services and necessary referrals of urgent or emergent nature available 24-hour, 7 days per week, access by telephone to a live voice (an employee of the PCP or an answering service) or an answering machine that ~~shall~~ must immediately page an on-call medical professional so referrals can be made for non-emergency services or so information can be given about accessing services or procedures for handling medical problems during non-office hours;
   f. Not refuse an assignment or disenroll a client or otherwise discriminate against a client solely on the basis of age, sex, race, physical or mental handicap, national origin, type of illness or condition, except when that illness or condition can be better treated by another provider type;
   g. Ensure that ADA requirements and other appropriate technologies are utilized in the daily operations of the physician's office, e.g., TTY/TDD and language services, to accommodate the client's special needs.

h. Request transfer of the client to another PCP only for the reasons identified in 482 NAC 2-003.03 and continue to be responsible for the client as a patient until another PCP is chosen or assigned;

i. Comply with 482 NAC 4-002.05 if disenrolling from participation in the NHC and notify the medical/surgical plan in a timely manner so that an Interim PCP (see 482 NAC 2-003.03E) can be assigned;

j. Maintain a medical record for each client and comply with the requirement to coordinate the transfer of medical record information if the client selects another PCP;

~~k. Utilize the Enrollment Broker Services and Public Health Nursing components of the NHC (see 482 NAC 2-000 and 3-000) as appropriate;~~

~~l~~k. Maintain a communication network providing necessary information to any MH/SA services provider as frequently as necessary based on the client's needs.

Note: Many MH/SA services require concurrent and related medical services, and vice versa. These services, include, but are not limited to anesthesiology, laboratory services, EKGs, EEGs, and scans. The responsibility for coordinating services between the Basic Benefits Package and the MH/SA Package (see 482 NAC 4-004.05), and in sharing and coordinating case management activities, is shared by providers in both areas.

A focused effort to coordinate the provision, authorization, payment and continuity of care is a priority for providers participating in the NHC. Each medical/surgical plan ~~shall~~ must monitor overall coordination between these two service areas, i.e., medical/surgical and MH/SA. The medical/surgical plan ~~shall~~ must ensure the PCP is knowledgeable about the MH/SA Package and other similar services and ensure that appropriate referrals are made to meet the needs of the client;

~~m~~l. Communicate with agencies including, but not limited to, local public health agencies for the purpose of participating in immunization registries and programs, e.g., Vaccines for Children, communications regarding management of infectious or notifiable diseases, cases involving children with lead poisoning, special education programs, early intervention programs, etc.;

~~n~~m. Comply with all disease notification laws in the State;

~~o~~n. Provide information to the Department as required;

~~p~~o. Inform clients about all treatment options, regardless of cost or whether such services are covered by the Nebraska Medical Assistance Program; and

3. Provide accurate information to the medical/surgical plan in a timely manner so that PCP information can be exchanged with the Department via the Provider Network File (482-000-22).

9. Provide a client handbook to the clients enrolled with the medical/surgical plan, other informational materials about NHC benefits that are easy-to-understand, and a comprehensive list of Primary Care Physicians (PCP's), specialists and ancillary service providers. Maintain written policies and procedures and provide such information to clients in a manner appropriate to the client's needs. The medical/surgical plan is prohibited from performing any direct solicitation to individual Medicaid clients. Any general marketing to Medicaid clients must be approved by the Department prior to implementation. Note: The PCCM Network is only required to maintain a network of PCPs. In the PCCM Network, the client has access to all specialty and ancillary service providers that are active and enrolled in the Nebraska Medical Assistance Program.

   The medical/surgical plan ~~shall~~ must comply with the following marketing guidelines (see 482-000-24, NHC Marketing and Client Information Procedure Guide):

   a. Obtain Departmental approval for all marketing materials;
   b. Ensure marketing materials do not contain any false or potentially misleading information (in a manner that does not confuse or defraud the Department);
   c. Ensure marketing materials are available for the client population being served in the designated coverage areas;
   d. Avoid offering other insurance products as an inducement to enroll;
   e. Comply with federal requirements for provision of information including accurate oral and written information sufficient for the client to make an informed decision about treatment options; and
   f. Avoid any direct or indirect door-to-door, telephonic or other "cold-call" marketing;

~~10. Comply with the Department's continuous Quality Assurance/Quality Improvement activities, provide health services meeting the Department's quality standards, and comply with all requests for reports and data to ensure that QA/QI performance measures are met (see 482 NAC 6-000);~~

~~11~~10. Meet all requirements of the Americans with Disabilities Act (ADA) and provide appropriate accommodations for clients with special needs. Ensure PCPs and specialists are equipped in appropriate technologies, e.g., TTY/TDD and language services, or are skilled in various languages and areas of cultural diversity/sensitivity, and/or the network is appropriately staffed to ensure an adequate selection for those clients who have special cultural, religious or other special requests;

~~12~~11. Coordinate activities with the Department, other NHC contractors, and other providers for services outside the Basic Benefits Package, as appropriate, to meet the needs of the client, and ensure systems are in place to promote well managed patient care, including, but not limited to:

   a. Management and integration of health care through the PCP, and coordination of care issues with other providers outside the medical/surgical plan, for services not included in the Basic Benefits Package (e.g., MH/SA services, Pharmacy, Dental Services, etc.), or for services requiring additional Departmental authorization (e.g., sterilization exceptions for age and consent period requirements, abortions, experimental or investigational treatment, HEALTH CHECK (EPSDT) treatment services not covered by the Nebraska Medical Assistance Program, transplants (except corneal), Nursing Facility Services, etc.);

b. Required referral/prior authorization requirements for medically necessary specialty and ancillary services. Authorization for physician to physician referral is not required;
c. Provision of or arrangement for emergency medical services, 24 hours per day, seven days per week, including an education process to help assure clients know where and how to obtain medically necessary care in emergency situations;
d. Unrestricted access to protected services such as emergency room services, family planning services, tribal clinics, etc., according to 471 NAC;
e. Clearly identified expectations for the PCPs, subcontractors and any other service providers participating in the client's managed care and documentation of that care for quality assurance/quality improvement purposes;
f. Retention of plan-maintained records and other documentation during the period of contracting, and for three years after the final payment is made and all pending matters are closed, plus additional time if an audit, litigation, or other legal action involving the records is started before or during the original three year period ends; and
g. Adequate policy regarding the distribution of the client's medical records if a client changes from one PCP to another, or from one medical/surgical plan to another according to Department specifications;

~~13~~12. For an HMO only, whenever possible, the HMO ~~shall~~ must use State-designated laboratories to ensure that lab results that involve infectious or notifiable diseases or diseases for which there are registries maintained by Federal, State and Local public health agencies. The Department ~~shall~~ will require the HMO to work cooperatively with the public health agencies to share appropriate service data and participate in other similar preventative and data collection initiatives that may be promoted by the Department and public health agencies. The laboratories utilized by the medical/surgical plan ~~shall~~ must comply with the Clinical Laboratory Improvement Act (CLIA);

~~14~~13. Comply with regulations providing for advance directives;

~~15~~14. Not refuse an enrollment or disenroll a client or otherwise discriminate against a client solely on the basis of age, sex, race, physical or mental handicap, national origin, or type of illness or condition;

~~16~~15. Require that all subcontractors meet the same requirements as are in effect for the medical/surgical plan that are appropriate to the service or activity delegated under the subcontract;

~~17~~16. Provide Member services;

~~18~~17. Maintain, at all times, an appropriate certificate of authority to operate issued by the Nebraska Department of Insurance;

~~19~~18. If an HMO, provide for a Physician Incentive Program (PIP) only if:
a. No specific payment is made directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to a client;

b. The medical/surgical plan provides PIP information to any Medicaid client, upon request, and the medical/surgical plan includes a statement on its marketing materials disclosing the client's right to adequate and timely information to related physician incentives;
c. The medical/surgical plan does not have PIPs placing a physician or physician group at substantial financial risk for the cost of services;
d. Where appropriate, the physician or physician group provides adequate stop-loss protection to the individual physicians; and
e. Where appropriate, the medical/surgical plan conducts client surveys;

~~20~~19. Comply with all applicable state and federal regulations, such as the prohibition against assisted suicide; inappropriate use of funds/profits, lack of mental health parity, and the noncompliance with the provisions of the Hyde Amendment;
~~21~~20. Prohibit discrimination against providers based upon licensing;
~~22~~21. Prohibit hiring, employing, contracting with or otherwise conducting business with individuals or entities barred from participation in Medicaid or Medicare;
~~23~~22. For an HMO only, ensure adequate numbers of medical specialists in its network to meet the needs of its members. Clients with chronic or severe medical conditions, e.g., HIV/AIDS, will be allowed to go directly to a qualified specialist within the medical/surgical plan's network;
~~24~~23. Ensure that PCPs inform clients about all treatment options, regardless of cost or whether such services are covered by the medical/surgical plan, and that health care professionals are not prohibited or otherwise restricted from advising clients about their health status, medical care, or treatment regardless of benefit coverage if the professional is acting within his/her scope of practice. This does not require a medical/surgical plan to cover counseling or referral if it objects on moral or religious grounds and makes available information regarding policies to clients who are enrolled with the medical/surgical plan, or who may enroll with the medical/surgical plan, within ninety days of a policy change regarding such counseling or referral services;
~~25~~24. Provide written notice to the client of any adverse action (i.e., denial or reduction) regarding the provision of services that complies with all federal and state requirements, as described in the NHC Marketing and Client Information Procedure Guide (see 482-000-23). Allow clients to challenge decisions to deny, limit or terminate coverage of services. Clients ~~shall~~ must be allowed to file complaints, grievances and appeals, according to 482 NAC 6-000;
~~26~~25. Comply with the Maternity and Mental Health Requirements in the Health Insurance Portability and Accountability Act (HIPPA) of 1996 the maternity length of stay and mental health parity requirements specifically requiring coverage for a hospital stay following a normal vaginal delivery not be limited to less than forty-eight hours for both the mother and newborn child, and the health coverage for a hospital stay in connection with childbirth following a cesarean section not be limited to less than ninety-six hours for both the mother and newborn child;
~~27~~26. For an HMO only, provide assurances that any amount expended for home health care services be provided with the appropriate surety bond;
~~28~~27. Report all fraud and abuse information to the Department;

~~29~~28. For an HMO only, comply with the provisions of 482 NAC 4-003.04 for provider payments; and

~~30~~29. Sign a contract with the Department and comply with all contract requirements and any other responsibilities specified by the Department in the overall operation of the NHC, and any other activities deemed appropriate by the Department and supported in regulations and/or contractual amendments;

~~31~~30. Comply with all applicable requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

4-003.02 HEALTH CHECK (EPSDT): The medical/surgical plan ~~shall~~ must develop a program to ensure the delivery of HEALTH CHECK (i.e., Early and Periodic Screening, Diagnosis and Treatment or EPSDT services).

HEALTH CHECK (EPSDT) is a priority for the NHC, and, as such, should be emphasized whenever appropriate and feasible with families who have children age twenty (20) and the younger. The medical/surgical plan ~~shall~~ must contact HEALTH CHECK (EPSDT) eligible children within sixty days of enrollment and encourage them to make an appointment for a health and dental screening. The required components are health screening, including medical, vision, hearing and dental screening (see 471 NAC 33-000). The medical/surgical plan must also counsel the family regarding the importance of health supervision and regular check-ups and assist in removing barriers to care. If necessary, the medical/surgical plan assist families with appointment scheduling and transportation.

At a minimum, efforts ~~shall~~ must include:

1. HEALTH CHECK (EPSDT) Screening: The medical/surgical plan ~~shall~~ must provide HEALTH CHECK (EPSDT) services according to 471 NAC Chapter 33-000.
   a. The medical/surgical plan ~~shall~~ must outreach to HEALTH CHECK (EPSDT) eligible children who need to be scheduled for HEALTH CHECK (EPSDT) examinations. Targeted groups are -
      (1) Newly Medicaid-eligible and other children who have not had a timely HEALTH CHECK (EPSDT) examination;
      (2) Children who have been identified as not having ever been screened or not having received HEALTH CHECK (EPSDT) services within established timelines based on the periodicity schedule; and
      (3) Children from birth to the second birthday, particularly infants and toddlers that may need immunizations, lead level testing, developmental testing and hearing testing.
   b. The medical/surgical plan may contact the EBS regarding -
      (1) Screening appointments missed without cancellation to determine the barriers to care, to assist in rescheduling the appointment, and to counsel the family about keeping appointments; and
      (2) Screening results from a referral for treatment and the client who does not follow up with treatment services as identified by the medical/surgical plan.